PSYCHOTHERAPY IN GENERAL MEDICINE

REPORT OF AN EXPERIMENTAL POSTGRADUATE COURSE

BY GEDDES SMITH

Associate, The Commonwealth Fund

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FOREWORD

THIS report represents the pooled thinking of the persons listed within it as participating in the course given at the University of Minnesota in April 1946, and that of three persons who, though not mentioned, were to a very considerable extent responsible for its success. These are Dr. William A. O'Brien, Director, Department of Postgraduate Medical Education, University of Minnesota Medical School; and Mildred C. Scoville, Executive Associate, and Dr. Lester J. Evans, Medical Associate, of the Commonwealth Fund.

G. S.

PSYCHOTHERAPY IN GENERAL MEDICINE

CAN doctors be taught to practice in their own offices the kind of medicine psychoneurotic patients need? Can they learn to use in all their practice the gist of what modern psychiatry has to say about human personality and the way it works? Can they get some idea of what comprehensive medicine means?

What follows is an attempt to answer these questions.

During the first two weeks of April 1946, twenty-five physicians attended a postgraduate course, at the Center for Continuation Study of the University of Minnesota, on Psychotherapy in General Practice. The immediate results of this course, which was characterized by an extraordinary rapport between instructors and students, were the recognition by both of new possibilities in the general practice of medicine, a warm response by clinic patients to their treatment, and a conviction on the part of most of the students that their usefulness and morale as physicians had been strengthened. Later results will be observed in follow-up investigation six months or a year hence. One man, a recent graduate of a good school, called the course "the most remarkable educational experience I have ever had."

This course was an experiment sponsored jointly by the Commonwealth Fund and the Division of Postgraduate Education of the University of Minnesota. Many thoughtful

physicians have long been troubled by the overswing of the pendulum, in medical schools and medical practice generally, toward what might be called organ diagnosis and fractional therapy and away from the art of medicine which encompasses the whole man. The impetus for this particular experiment came, however, from a group of military and naval psychiatrists and medical educators who met at Hershey, Pennsylvania, in February 1945, under the auspices of the National Committee for Mental Hygiene and the Fund, to discuss the needs of veterans with psychoneurotic reactions.* This group agreed that care of such patients must be given primarily by general physicians, and recommended that a pilot course, or courses, be set up at the postgraduate level to explore the possibilities of educating men in practice for this responsibility. The Commonwealth Fund undertook to provide an experimental course and called into consultation, to plan it, a number of psychiatrists with pertinent teaching experience, led by Dr. Thomas A. C. Rennie, Associate Professor of Psychiatry, Cornell University Medical College, and Dr. John M. Murray, who had organized and directed the psychiatric training program of the Army Air Forces at Fort Logan, Colorado.†

Around this nucleus a teaching staff was built up. It was drawn from the ranks of the younger psychiatrists, most of them fresh from war service, who felt that psychiatry had something that could and must be shared with general medicine and recognized the urgent need of collaboration from

* *Medicine and the Neuroses; Report of the Hershey Conference on Psychiatric Rehabilitation*, New York, The National Committee for Mental Hygiene, 1945.

† Dr. John C. Whitehorn, Professor of Psychiatry at Johns Hopkins University School of Medicine, though he was unable to participate in the teaching, shared helpfully in the early planning of the course.

general medicine in the care of the psychoneuroses. Of the following group, Drs. Bauer, Bond, Murray, and Romano and the psychiatric social workers were in attendance for two weeks, the others for a week each.

ELEANOR BARNES
Information Secretary, New York City Committee on Mental Hygiene
Formerly Chief Social Worker, New York University Clinics, New York University Medical School

WALTER BAUER, M.D.
Associate Professor in Medicine, Harvard Medical School
Formerly Colonel, M.C., Medical Consultant, Headquarters, 8th Service Command

DOUGLAS D. BOND, M.D.
Professor of Psychiatry, Western Reserve University School of Medicine
Formerly Major, M.C., Chief of the Neuropsychiatric Branch, Professional Service Division, Office of the Air Surgeon; Director of Psychiatry, 8th Air Force, Central Medical Establishment

HENRY W. BROSIN, M.D.
Professor of Psychiatry, University of Chicago School of Medicine
Formerly Colonel, M.C., Neuropsychiatric Consultant, Headquarters, 3rd Service Command

DONALD W. HASTINGS, M.D.
Professor of Psychiatry, University of Minnesota Medical School
Formerly Lieutenant Colonel, M.C., Chief of the Neuropsychiatric Branch, Professional Service Division, Office of the Air Surgeon; Chief Consultant in Psychiatry, 8th Air Force

M. RALPH KAUFMAN, M.D.
Psychiatrist, The Mount Sinai Hosiptal, New York
Formerly Colonel, M.C., Consultant Psychiatrist, Pacific Ocean Areas; Associate in Psychiatry, Harvard Medical School

JOHN M. MURRAY, M.D.
Private practice, Boston, Massachusetts; Consulting Psychiatrist, Massachusetts Institute of Technology
Formerly Colonel, M.C., Chief of the Neuropsychiatric Branch, Professional Service Division, Office of the Air Surgeon;

Director, Aviation Psychiatry Training Program, and Psychiatric Consultant to Army Air Forces Personnel Distribution Command, Fort Logan, Colorado; Consultant in psychiatry, Dartmouth College

THOMAS A. C. RENNIE, M.D.

Associate Professor of Psychiatry, Cornell University Medical College; Director, Division on Rehabilitation, National Committee for Mental Hygiene

Formerly Associate in Psychiatry, Johns Hopkins School of Medicine

JOHN ROMANO, M.D.

Professor of Psychiatry, University of Rochester School of Medicine

Formerly Professor of Psychiatry, University of Cincinnati College of Medicine; Instructor in Medicine, Harvard Medical School; Associate in Medicine, Peter Bent Brigham Hospital

KATHARINE M. WICKMAN

Psychiatric Social Worker, Pediatric-Psychiatric Clinic, Babies Hospital, Columbia-Presbyterian Medical Center; Instructor, New York School of Social Work (Columbia University)

Formerly Psychiatric Social Worker, Institute for Child Guidance, New York

HAROLD G. WOLFF, M.D.

Associate Professor of Medicine and Associate Professor of Psychiatry, Cornell University Medical College

The Division of Postgraduate Education at the University of Minnesota courteously made available for the course the facilities of the Center for Continuation Study and undertook to select a student group of twenty-five men representing the practice of medicine under varying conditions in communities of assorted size, chiefly in Minnesota and the neighboring states.* The University of Minnesota Hospital undertook to

* Twenty-three of those selected were general physicians or internists; most of the latter were in group practice. One was a pediatrician, one a dermatologist. Thirteen men were in their thirties, ten in their forties, two in their early fifties. Five were veterans who had spent the previous three months in postgraduate study at the University of Minnesota in

provide patients for clinical teaching, which from the first was recognized as an indispensable part of the course. Dr. George N. Aagaard, Jr., Assistant Professor of Medicine, in charge of the medical outpatient department, made all arrangements for the clinical part of the course and selected patients for teaching purposes. Assisting in the clinical teaching was a group of psychiatrists on the staff of the University of Minnesota Medical School, as follows:

Dr. S. Allan Challman, Clinical Assistant Professor of Neuropsychiatry

Dr. Lillian Cottrell, Assistant Professor of Neuropsychiatry

Dr. Harold B. Hanson, Clinical Assistant Professor of Pediatrics and Neuropsychiatry

Dr. Robert G. Hinckley, Associate Professor of Neuropsychiatry

Dr. Reynold A. Jensen, Associate Professor of Pediatrics and Neuropsychiatry

Dr. Hyman S. Lippman, Clinical Associate Professor of Pediatrics and Neuropsychiatry

Dr. Burtrum C. Schiele, Associate Professor of Neuropsychiatry

The length of the course was dictated by practical considerations. Precedents at the Center for Continuation Study pointed to a week as the outer limit of courses for active practitioners. Some of the teaching group, despairing of covering the ground adequately, set three or four weeks as a minimum. Since only a short course seemed likely to set a pattern that

preparation for a return to civilian practice. Two others were about to begin residencies. Of the other eighteen, three had practices in the Twin Cities, five others in cities of 25,000 or more; seven in cities of between 1,000 and 25,000; and three in towns of 1,000 or less. Students paid fees for board, lodging, and tuition at the rates usually charged at the Center.

would be generally followed and since it would be difficult to hold either students or instructors for longer than two weeks, that period was adopted as a workable compromise.

Two weeks is a short time in which to reorient men in medicine. The schedule was a full one. After some experimentation it took form as follows:

Monday through Friday

8:30-10:20	Lecture, followed by discussion (entire student group)
10:30-12:00	Section meetings devoted to discussion of clinical work (instructor and five students)
1:00- 2:30	General seminar (entire student group) or section meetings
3:00- 5:00	Supervised clinical work (one instructor and one assistant to each five students)
8:00- 9:00	Films and special seminars as requested

Saturday

8:30-12:00	Review, case presentations, and discussion

In planning this schedule the intent was that the morning lectures would lay the theoretical groundwork for the kind of medical care that the students were to learn; the afternoon seminars would provide opportunity for the presentation and discussion of methodology; and the clinic sessions, with the section meetings at which clinical procedures could be discussed in detail, would help the students to get and assimilate first-hand experience in the care of patients. As it turned out, the lectures and the section meetings proved to be successful vehicles for teaching; the large group seminars less so. Discussion in the full group of twenty-five, and in the presence of a number of auditors not enrolled in the course, never quite satisfied either the students or the teachers, and the seminars became in effect minor lectures given at a time of the day

when no one was quite as fresh as he had been at the morning session. The best teaching was done in section meetings, where give and take was easy and continual, and where the significance of the clinical work was hammered out case by case.

Both the didactic and the clinical parts of the course underwent some change during the two weeks. While the morning lectures followed most closely the plan worked out in a long series of preliminary conferences, they were given at a simpler and often more colloquial level and in broader terms than had been anticipated. The afternoon seminars were handled still more freely and two of them were replaced by section meetings when it became apparent that it was practical to present the theoretical material more briefly than had been planned, and that the students needed more time than had been provided for thrashing out clinical problems. The program as given was as follows:

LECTURES AND GENERAL SEMINARS

Monday, April 1
Morning: General Orientation
Lecturer, Dr. Rennie
Discussion leader, Dr. Bauer
Afternoon: Patient-Physician Relationship
Leader, Dr. Kaufman

Tuesday, April 2
Morning: Normal Personality Development
Lecturer, Dr. Murray
Afternoon: Section Meetings
Evening: Showing of Film: Combat Fatigue; Irritability
Discussion leader, Dr. Bond

Wednesday, April 3
Morning: Normal Personality Development
Lecturer, Dr. Murray
Afternoon: Psychotherapy
Leader, Dr. Romano

Thursday, April 4
Morning: The Meaning of a Psychoneurosis
Lecturer, Dr. Kaufman
Afternoon: Section Meetings
Friday, April 5
Morning: The Meaning of a Psychoneurosis
Lecturer, Dr. Kaufman
Afternoon: Diagnosis of Psychoneurosis
Leader, Dr. Romano
Saturday, April 6
Morning: Summary by Dr. Rennie
Monday, April 8
Morning: Anxiety
Lecturer, Dr. Romano
Afternoon: General Principles of Psychotherapy
Leader, Dr. Murray
Evening: Special Therapies
Leader, Dr. Hastings
Tuesday, April 9
Morning: Anxiety
Lecturer, Dr. Romano
Afternoon: Common Psychopathology
Leader, Dr. Brosin
Evening: Sex Education and Marriage Counseling
Leader, Dr. Murray
Wednesday, April 10
Morning: Common Psychopathology
Lecturer, Dr. Bond
Afternoon: Care of Veterans
Leader, Dr. Hastings
Thursday, April 11, and Friday, April 12
Morning: Physiological Functioning as Affected by Emotions
Lecturer, Dr. Wolff
Afternoon: Case Presentations
Discussion led by Dr. Bauer and psychiatrists
Saturday, April 13
Morning: Case Presentations, Discussion, and Summary by Dr. Murray

Some men felt and expressed an understandable desire for more time for reading and the assimilation of new material,

but the group as a whole followed this concentrated instruction with surprising ease and with unflagging attention. There were few vacant chairs at the beginning of any session; virtually none at the end. Only the three evening sessions drew definitely unfavorable comments. The students were so full of the subject that they spent hours at night talking with each other and with members of the teaching staff, and they much preferred this to formal exercises in the evening.

On the clinical side, the trend was to take patients more and more as they came, with lessening emphasis on the selection of specific teaching problems. In preliminary discussion, some of the instructors had asked for patients illustrating various aspects of acute anxiety, including perhaps a few veterans, who might respond visibly to brief but reasonably intensive treatment. The general and special medical clinics of the university hospital held far less of such material than these instructors hoped to find, but more than made up for this lack by offering in large abundance cases of long-standing distress, more or less disabling, of the sort that every general practitioner sees in his own office. Some of these patients had been known to the clinic for a long time; some had had varied medical and surgical treatment elsewhere: one woman had had eleven gynecological operations. They complained of pain in the stomach, abdomen, back, legs, and so on, flatulence, palpitation, nervousness, fatigue, sleeplessness, headache. Among them were many middle-aged women, some farm laborers, some unhappy young wives of soldiers or war workers. There were few textbook psychoneuroses but many psychoneurotic people in the group; it was an excellent sample of the persistently unwell.

At the beginning of the course a few patients had been studied by one of the psychiatric social workers in the teaching

group in the effort to clear the way for incisive therapy. As it became clear that the clinical work done in the course was more likely to demonstrate chronic psychoneurotic situations than acute anxiety, cases were taken about as they came and were put in the hands of the student-doctors as soon as a minimum physical work-up had been completed by the regular clinic staff.

Methods of supervision varied from one instructor to another; in general the student was left to make his own contact with the patient and was joined by the instructor only for a part of the interview. Some instructors spent much time with the students immediately after the patients left, and cases were thoroughly discussed in the small section meetings.

The course opened on Monday morning with a general introduction which amounted to a preview of the lectures to follow and which covered a good deal of ground rather rapidly. At the section meetings which followed the men were briefed on the point of view with which they would meet patients in the afternoon and the methods they would use in talking with them. A history outline was presented and in some sections reviewed in detail.* The purpose of the interview, its tactics and some of its techniques, and its philosophy —its emphasis not so much on getting facts as on feeling out the patient's attitude toward those facts, on helping the patient to tell himself his own story—were discussed. The students were asked to *listen* to the patient, to give him a sense of undi-

* Not much was heard of the history outline after its introduction. The tempo of the course was such that emphasis quickly fell on the give and take of actual treatment situations; it was tacitly recognized by both instructors and students that technical details must be assimilated later and at leisure.

vided and unhurried attention, and specifically, in the clinic, to talk with patients for an hour instead of the ten or fifteen minutes they were accustomed to give in their offices.

The first afternoon seminar was devoted to what proved to be one of the two or three most fertile concepts offered in the course—the patient-physician relationship. This was no medical cliché, nor was it presented in psychiatric terminology as transference and counter-transference. What happens between doctor and patient was first defined in terms of what the patient feels about his own illness and about the person who undertakes to treat it. The doctor has both real and symbolic values: he knows medicine, and he is, or may be, the source of emotional satisfactions—security, sympathy, understanding. The patient tends to endow the doctor with the attributes of some key figure in his or her own life—the indulgent or the harsh father, for example—and reacts accordingly. The relationship may thus have both positive and negative aspects. When it is positive, it is a potent element in therapy. The doctor is often his own best medicine. To give the patient freedom and confidence at the very first interview is to make a good beginning on therapy.

With this preparation the students plunged into the handling of their own patients in the medical clinic, some with a considerable measure of ease and success, some with neither. Naturally they were not equally skilful in playing the role of listener or in guiding the conversation into areas where what the patient said threw light on the pattern of his troubles. Some clung to inadequate organic explanations of the patient's symptoms. Sometimes a man seeing his first patient would miss completely the import of what the patient told him. Sometimes the instructor, who usually came in just before the end of the hour, quickly brought out factors the student had

missed. This was an instructive experience, and the second patient seen was likely to be better handled than the first.

At the end of the first day the faculty group felt that instruction had gotten rather ahead of schedule. One student had been heard to remark, "They're giving us an awful lot, but they've taken the hot air out of it." Some of the men at least were eager for more and talked right through the evening. At a corridor conference where the treatment of a twelve-year-old girl was under discussion, one student said, "Well, then, you talk her into eating." The instructor's answer was, "You don't talk her into it; you let her talk herself out of the reasons for not doing it"—and that summed up the lessons of the day.

On the second and third mornings a basis for the understanding both of the patient and of the relationship between the patient and the doctor was laid in lectures on normal personality development. These drew upon the Freudian psychology in which most of the instructors had been trained and which gave unity to what they taught. But much abstruse matter had been cleared away from it, and only a few basic concepts remained. These were given in simple terms — the Freudian *id* became "old man river" — and illustrated in homely ways. The child, whose basic relation to the world is one of extreme dependence, grows through several stages of instinctive self-gratification in which he is ruled by the need to be loved and to be happy and free of punishment; gradually learns to relate himself to an objective world; and takes into himself little by little, by identification with the father and other adults, that authority which at first impinged upon him in the form of taboo and punishment. In adolescence the tension between instinct and conscience, dependence and self-reliance, love and hostility, is heightened and behavior may

normally take forms which would seem psychoneurotic in later life. Eventually, if growth is successful, the adult personality — characterized by maturity, freedom, and the capacity to dispose freely of the energy arising from instinctive sources—is formed. But the conflicts go on, and may give rise at any time of life to the symptoms of maladjustment.*

From the idea that the emotional life has its own natural history, and that while the healthy individual progresses from one stage of emotional development to another he often slips back, it was easy for the students to pass to the idea that childhood patterns of dependence, with or without accompanying hostility, may recur in the relation between patient and physician. This reinforced what they had been told previously about that relationship. As a footnote to these considerations a motion picture illustrating some phases of hostility and its management, released by the Navy for training purposes, was shown and discussed at an evening session.

It had been intended to follow these lectures by talks on the interview and on history-taking, but by this time the students were already so deep in the problem of what to do with the patients they were meeting that the first of these seminars was given up for section meetings and the second was replaced by a lecture which put psychotherapy—a term which still carries for many physicians a hint of something esoteric—on a simple footing. Psychotherapy, it was said, is the use of psychological measures in the treatment of sick people. The general practitioner may alter the patient's environment by dealing with the family, a man's employer, or a child's teacher; may increase the patient's understanding of

* Although it was not the intent of these lectures to discuss child psychology in terms of the pediatric and parental care of children, this application was quickly made by students in discussion.

his situation and correct his misconceptions; may support the patient by reassurance, the discreet use of drugs, physiotherapy, and suggestion; and may give him some release of emotional tensions through the interview (avoiding unconscious material) and through diversions, hobbies, and the like. All this sounded not very different from what a family physician might do without calling it psychotherapy, and discussion, in apparent recognition of this fact, turned quickly to what the doctor is accustomed to call the art of medicine.

In these first three days students took what was offered with an easy acquiescence which somewhat surprised the instructors. In some, it developed later, this was a mask for confusion; they felt themselves at sea. In others, it was evidence of a greater preparedness for this range of ideas than the teachers had hoped for. In either case it took time in this unfamiliar situation for men to get enough confidence in themselves to challenge what was being given them and to speak out in open session.

On the fourth day things came to a head. One general practitioner, who had run into a dead end in his first interview with a patient, pounded the table in section meeting and said, "What do I do now?" In the large group a doctor asked whether after all it wasn't a good idea to treat the psychoneurotic patient for the organic condition he thought he had, even though the doctor knew better. One young student asked pointedly for some generalizations. One section devoted its afternoon session to a frank discussion of the goals of the course. Some students were asking about psychoanalysis and whether insulin shock was better than electrical shock. Another said, "I think we will be able to take care of the presenting complaint, but we won't be able to cure the patient." All of them wanted to know how far to go with

patients. In this section the instructor summed up by saying, "I think your general handling of patients will be definitely better and that as a result, if you maintain this point of view and approach, you will touch the lives of very many people more constructively than you might otherwise have done. If you get that out of the course, it is enough." All this discussion helped to clear the air, and when that same afternoon the man who had pounded the table had the heart-warming experience of hearing an elderly patient disburden herself of painful memories she had kept hidden for years, and saw the relief she got in doing so, his morale shot upward.

On this day and the next the morning lectures were on the meaning of a psychoneurosis. The nub of the argument was that psychoneurosis *had* meaning, that symptoms form part of a purposive pattern which represents the patient's reaction, in terms of his own life experience, to a situation which he finds unmanageable by other means, a compromise solution of a conflict between different parts of the personality. To understand the psychoneurosis, one needs to recognize that threatening ideas and impulses are repressed, but retain in the unconscious—"a kind of seething thing"—their emotional drive and tension. Such forces, pitted against external forces and the repressive mechanism, may create intolerable strain, so that something must give way a little. The psychoneurosis offers partial escape from such a conflict, often on a symbolic level. Symptoms, therefore, may hold a clue to the nature of the underlying conflict, and frequently follow a repetitive pattern. The major types of psychoneurotic reaction—hysterias, phobias, and obsessive-compulsive behavior—were described and illustrated at some length, but no stress was put on formal classification.

On the afternoon of the fifth day this discussion was imple-

mented by suggestions for the systematic diagnosis of a psychoneurotic state. One needs to take account, it was said, of the presenting complaint, of its similarity to previous experiences, and of the onset of the trouble, with respect not only to the precipitating factor but also to the setting in which it occurred and the patient's preparation for it. The patient's behavior and history should yield evidence as to the existence of conflict and some clue to the factors which determine the symptoms. So another cardinal point was firmly made: that a valid diagnosis of psychoneurosis can be made only on positive evidence and not merely by exclusion of organic factors.

By Saturday of the first week, when the time came to sum up, many of the students, listening to patients, asking them clumsy but essentially pertinent questions, hearing them talk as some of them had never talked to a doctor before, had the excitement that comes from simultaneously knowing and feeling the dynamic quality of human relationship. As doctors they had come alive for their patients; their patients had come alive for them. Those men who had been unable to reach this point themselves had seen their instructors touch the springs of feeling in their patients and knew that the result was good. For their part, the instructors were exhilarated by a quicker response from the students than they had dared hope for. The week ended on a high note of shared enthusiasm.

Some of the students practiced in towns near enough to Minneapolis to go home on the week-end, and one of the older men came back on Monday eager to tell how among the ten or eleven patients he had seen, three had given him opportunity to try out, with some success, the new techniques he had learned. Had the course ended at this point, the students would without doubt have carried back into their practices new ideas about the meaning and function of an interview with a

patient; a new sense of their own worth to the patient; and a determination to put more time and more humanity into their contacts with patients. But their enthusiasm might well have lapsed as old difficulties began to reappear. They needed to be steadied and strengthened by a more realistic understanding of the possibilities and limitations of psychotherapy and its relation to physical medicine. This was the task of the second week.

As the week opened two instructors had left, two new ones were introduced, and sections were reassigned. There was some loss of continuity and momentum as new instructors took over the supervision of cases; the rapport already established was important to the students. On the didactic side, these changes were stimulating rather than disturbing; from the first all the instructors had participated freely in discussion and the addition of new points of view and new methods of presentation was interesting to the students. For example, a simple wavy line, drawn on the blackboard on Monday to illustrate the oscillations between adult and adolescent or childish levels which are to be looked for on occasion in all adults, figured in discussion throughout the week as "the Brosin curve." Yet the course had reached a point where heavy going was to be expected.

The first lectures of this week dealt with anxiety as the major source of psychoneurotic difficulties. Anxiety was defined as an unpleasant emotion signalizing a threat to the personality from either without or within, accompanied by characteristic physiological changes. The psychology of acute illness was taken as a starting point for this discussion, with emphasis on the value of anxiety in mobilizing the defenses

of the personality. As the sick man withdraws his interest from the outer world and turns it inward, it was said, he regresses for the time being to the dependence of the child, thrusting on the doctor and nurse the parental role; in convalescence he "grows up" again. This is normal or realistic anxiety. It was contrasted with the anxiety of the psychoneurotic, arising from a dangerous conflict of forces within the personality, and probably a factor in all psychoneurotic symptoms. In this the degree of the patient's anxiety is out of proportion to its ostensible causes. In the adult such anxiety frequently arises from conflicts over hostility (especially hostility toward loved persons), sexual excitation, and other stimuli of comparable intensity. The common defenses against anxiety — ranging from denial of the threatening factor to sublimation of the unacceptable impulse—were enumerated and briefly defined. This was the only point at which a long string of psychiatric terms was injected into the course without much time for explanation or assimilation. The essential point made was that all these defenses obeyed the logic of the emotions—a very different thing from the logic of the intellect.

The afternoon seminars accompanying these lectures were devoted to a continued discussion of psychotherapy and psychopathology, with somewhat more emphasis on the doctor's share in the relation between patient and physician, and a more detailed discussion of specific psychoneurotic mechanisms, than had been given before. At one of these sessions a tentative but deliberate attempt was made to focus discussion on the emotional status of the doctor himself as it influenced the interview situation. There were moments of tense silence which suggested that the students were stirred and were thinking seriously about themselves. Few were ready to talk freely to that point in such a setting, but some did so privately.

Evening sessions on Monday and Tuesday explored problems on which the students, greatly interested in problems of treatment, had asked for help. Such special therapies as electrical and insulin shock and sodium pentothal narcosynthesis were treated as techniques which the doctor should be aware of but should not attempt to use himself. Attention was drawn also to the significant problem of the delirious patient as seen in the general hospital and in practice. Sex education and marriage counseling were discussed in terms of demands frequently made upon the general practitioner, but the students were cautioned that the cure of deep-seated problems of sexual dysfunction was something they should not attempt. This was a course in psychotherapeutic medicine, not psychiatry, and though the dividing line was not always drawn sharply, it was never forgotten.

The morning lecture on the ninth day of the course also dealt with areas where it is the general practitioner's function to know what is going on but not to take responsibility for treatment. This discussion of common psychopathology was keyed, nevertheless, to the doctor's familiar experience. Just as normal reactions to illness had been used as the starting point for the discussion of anxiety, so normal grief was considered as a baseline for the recognition and understanding of the severe depressions, in which grief is overlaid by guilt. The noticeable traits of the early schizophrenic were described and a clear picture was given of the psychopathic personality —the patient with a disordered character structure. The burden of this lecture was to leave the students with a few essential warnings as to what not to do with patients in these categories.

This was followed by a seminar devoted to the care of veterans. Though two sessions had originally been set apart

for the discussion of war psychoneuroses, this topic aroused only lukewarm interest. Throughout the course those instructors who had been active in the armed forces had drawn freely on their experience to illustrate psychoneurotic mechanisms and methods of treatment, and while the students were always greatly interested in these case stories, they seemed to feel little need, in thinking about their own practices, to set the psychoneurotic veteran apart from their other patients.

The formal didactic exercises were completed with two lectures on physiological functioning as affected by the emotions. These gave experimental evidence, obtained by the quantitative methods of the physiological laboratory, that emotional states were linked with fluctuations in gastric, cardiac, vascular, and respiratory function. This group of students, chosen in the first place as good doctors, had by now accepted on clinical evidence the validity of the emotions as a factor in the patient's disease. They did not need laboratory confirmation of the fact that inner conflict may be accompanied by measurable changes in vascular tone in the skin, gastric mucosa, or turbinates; but as physicians trained to value quantitative methods in medicine they felt more comfortable about the underlying thesis of the course in the face of data of this sort.

In the clinic some students found themselves bumping along the hard road of reality. After two or three interviews with the same patient many of them were, as one instructor put it, stuck. The new patients who came in were more and more like the discouraging cases at home. The students began to wonder what they would do with such people in their own offices when there was nobody to turn to for help. Patients with proven physical lesions *and* emotional handicaps challenged the doctors' ability to hold the two aspects of medicine

in balance. Patients already on the road to definite psychoses and other patients whose difficulties called aloud for skilled psychiatric care seemed to whittle down the opportunities for the general practitioner. It was at this point that previous plans for the closing sessions of the week were laid aside and it was decided to devote three seminars to case presentations before the entire group, with the student-doctor outlining his findings, the psychiatrist-instructor tracing the emotional pattern, and Dr. Bauer, as consultant in internal medicine, relating the organic findings to the overall medical picture.

These dry clinics were received with much interest by the students and helped put the whole course into perspective. The first case presented was that of a farm wife in her thirties, rather badly handled by physicians (including a psychiatrist) before brucellosis was diagnosed and treated. Over and above the picture of somatic disease there were clear evidences of emotional strain associated with disabling fears. The student said frankly that this patient felt worse rather than better after each interview, and pointed out with much humility the mistakes he had made in handling her, particularly by probing sensitive areas. She kept coming back, however, and had already made some progress when, at a final interview, the instructor was able to give her a good deal of relief by reassurance and suggestion and by explaining the origin of her fears. The story had a tonic effect on the other students, some of whom had been a little frightened by frequent warnings about the damage they might do if they pressed the patient too far, and they tackled their own patients more confidently that day.

The second case was that of a woman in her late fifties, in and out of the hospital for ten years, troubled about a senile husband, and with both grave and minor physical disorders. The consultants at this course had agreed that her present

complaints could not be caused by her physical condition. The student had been "appalled that they dared say such a thing in the face of such structural changes." This was a case in which the common predilections of the medical man were hard to give up. If there is specific organic pathology, why look further for an explanation of the symptoms? It was crucially important that the students should see that if the patient is to be adequately treated positive evidences of emotional difficulty must be followed up just as faithfully as indications of physical damage. The point was firmly made when the case was discussed by the psychiatrist and the internist together, and some implications for the care of the aging and the aged were developed as a by-product.

The third case presented at length was that of a laborer in his thirties, much treated by a variety of physicians in a variety of ways for disabling muscle pain. There was a question of diagnosis here which the consultant, an internist with long experience in joint diseases, was able to settle with authority. The story led back to a frustrating life in which a person of passive temperament took the neurotic road as the only answer he could make to a combination of inadequacy and bad luck. This was a case in which psychotherapy at any level within the general practitioner's reach came too late, because symptoms had been firmly fixed by overexamination and overtreatment based on the wrong premises. The primary lesson drawn from it was that such functional disorders need to be treated on the emotional side before the body learns habits of reaction which it cannot unlearn. It was also implied that better diagnosis on the physical side is as important as better and earlier diagnosis of the emotional situation.

These cases, and some that had been discussed in the section meetings, made it clear that there were many patients whom

the doctor could not hope to cure; that the doctor would often be fortunate if he could use psychotherapy as effectively as the internist uses insulin—as a means of helping the patient to adjust his life to irreversible handicaps. As one instructor put it, the doctor had to help some patients to help themselves—to live with their psychoneuroses. This called for careful definition, in each case, of reasonable therapeutic objectives. The patient is a person needing help; the function of the doctor is not to play God, but to give help at any and all points where after thoughtful study he sees his way to do so, to treat the whole man to the best of his ability.

The course ended with a brief review that ran somewhat as follows:

We began by looking into the development of personality. We took a view of the child—what he was like and why he was that way. We sketched his emotional life and the vicissitudes which it undergoes in its development. We took cognizance of the tremendous dependence of the small child on his parents, and recognized its emotional intensity. We followed emotional development through adolescence to maturity.

We saw that sometimes the personality does not grow to its normal stature; we saw what happens when development goes askew. We saw also that the human organism is always in a state of relative balance—never complete, never entirely at peace. In the psychoneurotic we saw an individual out of balance. We saw that the personality can be shattered by the impact of an overwhelming situation, or cumulatively destroyed by repetitive smaller attacks. When that threatens, we saw, a number of defense devices come into play—unrealistic so far as the mature intelligence is concerned, but necessary to protect the individual against the pain of anxiety. We saw how these defense devices — to some extent specific to the individual—group themselves into patterns and series and sometimes build themselves up into syndromes. To these syndromes we gave names: hysteria, compulsion neurosis, depression,

and so forth, and we sketched briefly the common forms of severer psychopathology.

We learned that the psychoneuroses underlie many of the complaints that patients bring us for treatment and that we cannot diagnose or treat such patients helpfully or with satisfaction to ourselves without taking the emotions into account—not as a last resort when organic diagnoses fail, but as an integral part of our job as doctors. We learned something of the common methods of relieving emotional stress; in particular, of the tremendous power for good of the relationship between the doctor and the patient. We came to respect the therapeutic value of skilful, objective, sympathetic listening.

Clinical teaching is the crucial part of a course like this. The instructors felt that the meaning and methods of psychotherapy could not have been conveyed adequately by lectures and discussions alone. As one student remarked: "The lectures are fine, but the doctors in the clinic show you something you can't put into words." Borrowing patients from the medical outpatient services, however, involved certain inconveniences and hazards. Though it was not easy to incorporate twenty-five visitors into the regular routines of a large teaching clinic, schedules were staggered and the operation went off more smoothly than might have been expected. The hazards related to the establishment of doctor-patient relationships which had to be broken so soon. The psychiatric social workers on the teaching staff helped in preparing patients for this brief experience and in tying up the loose ends when they were turned back to the permanent staff. One spent the week before the course in liaison service of this sort and in the social study of selected patients. The collaboration of members of the psychiatric staff of the University of Minnesota in clinical supervision was another aid to continuity. This problem would have

been more difficult had a greater number of acutely ill patients been seen.

Because of popular misconceptions as to the implications of psychiatric care, patients selected for teaching were told that they would have an opportunity to see a "nerve specialist." Some, who had not recently been seen in the university hospital, received a form letter even less specific:

> We have recently reviewed your University Hospital medical record and we believe that you would benefit from attendance at a special clinic which will meet at the Medical Out-Patient Clinic on . . . . . at . . . . p.m.
>
> An appointment slip is enclosed. If you find it impossible to keep this appointment, please let us know by return mail.

Occasionally a patient came in who disliked or was dissatisfied with the interview technique. The great majority, however, welcomed it and came back for more. The clinic director estimated that not more than one return appointment out of twenty-five was broken. The patients not only came back but they told the student-doctors how they felt about it in terms more familiar to the instructors than to general practitioners: "I've met the first doctor who ever took a real interest in me and let me tell my story." The release of tension was obvious in many patients; in some instances it was coupled with enough symptomatic improvement to make a deep impression. One woman resumed normal activity, at least for the time being, after two months in bed. "The interview technique was startling in its results in so short a time," one student wrote.*

The following table shows the distribution of the 279 visits made by the 121 patients seen by the student group:

* The staff of the medical outpatient service is making follow-up studies of patients seen in this special clinic.

Visits per patient	*Number of patients*	*Total visits*
1	40	40
2	36	72
3	20	60
4	20	80
5	4	20
7	1	7
	121	279

The interesting point here is that 37 per cent of the patients were seen three times or oftener in a total of ten clinic sessions. These patients had been chosen from the general medical clinic and from the clinics for arthritis, cardiac disorders, dermatology, gastroenterology, hypertension, neuropsychiatry, and obstetrics-gynecology. About three-fourths were women; considerably more than half came from small towns or the open country; a few were in their teens, a few more were young adults, but many more were in their middle or later years.

The intensity of treatment varied, of course, with the student, the instructor, and the case. Some of the instructors were particularly adept in making teaching points after brief contacts with patients; others were interested in demonstrating the cumulative results of repeated interviews. The two students who saw the largest number of patients — eight and seven respectively—saw none of them more than twice. Most of the men had a somewhat more concentrated experience; three students saw six patients each; twelve saw five; four saw four; and the remaining four students three each.

Naturally, no student made final disposition of any case. Those patients who had served their purpose for teaching, or

with whom the student had gone as far as it seemed likely that he could go, were referred back to the medical clinic, with a final note in the record summing up the student's impression. Students were asked to keep separate notes of any data too personal to appear in the clinic record. Twenty-three patients in need of continued care at the psychiatric level were referred to specially assigned members of the psychiatric staff or to the psychiatric service of the department of pediatrics, and fuller information about them was transmitted, in most instances both verbally and in writing, to the person assuming responsibility.

The assignment of two persons, an instructor and an assistant, to each group of five students in the clinic was barely adequate for good supervision: some men got less than would have been desirable, particularly during the earlier part of the course when two interviews were scheduled for each student each day.

The greatest weakness of the clinical teaching, from a theoretical standpoint, was the fact that the students did not work up their cases fully from the beginning. Ideally a general physician or internist should be taught by doing what he would do in good practice — taking a complete history, making a physical examination, and securing what laboratory or x-ray data he felt he needed, weighing one diagnostic indication against another until he reached a well-founded and well-balanced opinion as to the causes of the patient's condition. Because the psychotherapeutic use of the interview was an unfamiliar technique and because time was short, these students took their physical and laboratory data in most instances from the record, and related physical data gotten by other people to what they were getting for themselves on emotional issues. Had they been young and inexperienced,

this might have skewed their thinking; but since nearly all of them were seasoned practitioners, long accustomed to conventional diagnostic procedures, there was little danger that they would skimp their physical medicine when they went back to their own offices. It was necessary, however, to challenge them from time to time to make sure that they kept the balance even, and at best the dichotomy was unfortunate.

In this situation the students and instructors leaned heavily on the internist who served as general medical consultant both in the seminar room and in the clinic. Dr. Bauer's wide knowledge of medicine enabled him to speak with authority on many problems raised by the medical history of the patient and to evaluate the patient's present condition in terms of accepted clinical considerations. His own interest and skill were broad enough to bridge the gap often left between somatic and psychological study of a given patient. It seems evident that if this gap is to be bridged, internists and psychiatrists should share in the teaching of psychotherapy for general practitioners, under whatever auspices it is given.

The two psychiatric social workers attached to the teaching group also gave consultant service in the clinic and in discussion. Because most of the men in this course practiced in communities where skilled case work was not available to them, or was available only from public employees with many prior claims on their time, it would have been foolish to teach them to place much reliance on social work collaboration. Representatives of social service agencies in Minnesota were given an opportunity to tell them what facilities were at hand in that state. In occasional cases seen in the clinic where social work had been done in Minneapolis or obviously needed to be done, the two consultants acquainted students with its methods. With experience and skill in analyzing the emo-

tional patterns of parents and children, these women were often able to interpret such material as it presented itself in the clinical handling of patients enmeshed—as most patients are—in the complications of family life.

Near the end of the course the men were asked to comment on it in writing. What they wrote documented what they had been saying to each other and to the instructors. Few said in so many words, but many implied, that the course had given them a new outlook on medicine. This was true especially at three interrelated points: their attitude toward patients; their attitude toward the causes of disease; and their treatment of chronic illness. The oldest physician in the group wrote:

> One of the most valuable things I have learned is a new concept of the doctor-patient relationship. This is a most interesting, helpful, and at the same time humbling concept.

An internist in group practice:

> Definitely I got a new orientation as to the relationship between the physician and the patient, as well as the increased appreciation of the necessity of viewing the patient as an individual; that an illness in a patient is not just a disease of the heart, stomach, or what not, but the dysfunction of the whole man.

A general practitioner from a very small town:

> During these past two weeks I have gained a new concept of people in their relation to illness. Although I have been unconsciously applying some of the principles expounded by the faculty, it was in a more or less haphazard manner without an understanding of what I was trying to accomplish. I had a definite antagonistic attitude toward

many patients in whom I could find no organic basis for their complaints. I will now be able to approach these patients with a new attitude more beneficial to both patients and myself.

A student who at first was skeptical and confused came to see clearly the need of a new kind of diagnosis:*

I believe this course has been of very much help to me because, in the first place, we have a new slant on our patients. We have all had the type of patient who does not become well and we have exhausted ourselves, and the patient also, looking and examining for physical conditions that are not there, thereby making ourselves and the patient thoroughly disgusted, and in the end have produced no benefit . . . I now feel that psychotherapy can be studied much more effectively after its introduction to us by these teachers.

A young physician who had one of the most interesting cases seen in the clinic made this discriminating statement:

This course has been most effective in enabling me to better handle my chronic cases. I have no illusions that I will be able to "cure" a large percentage of patients that come to me with emotional complaints simply by using the superficial psychotherapy we have been taught to handle in this course. A few I will help tremendously; many I will be able to help a little; but many more I will not be able to reach at all. But with all of them I will be more comfortable.

Another:

I need no longer feel frustrated at not *curing* most of my patients; . . . one may justifiably feel content to help carry some persons along at a level considerably lower than a cure.

* The dilemma that arises in conventional diagnosis is seen also in treatment. It was stated frankly in one of the section meetings by a doctor who said of the office practice he was accustomed to: "It's a fast brush-off. You've got to give them medicine if you don't give them psychotherapy."

Comment like this seemed to show that the men who took this course kept their feet on the ground. They did not expect too much, but they knew they had learned something, and believed that what they had learned would help them in their practice. There was no indication that they exaggerated their competence, or fancied that they were psychiatrists in the making. They needed reassurance more than restraint. Perhaps the least optimistic among them was the man who wrote, in answer to the question, "What parts of the course were least helpful?":

For me, strangely enough, the clinical work—probably because it is difficult to change old habits and adjust to new methods. If the available manpower permitted, it might have been helpful to sit in with an instructor for the initial interview. This is not to say that I derived no benefit, for I had more opportunity to explore the emotional background in a couple of cases (asthma and arthritis) than I will have in my own practice.

One of the older men wrote frankly:

I do not believe it has been clearly shown how we should utilize the information obtained from the patient in actually helping him. In other words, the course has explained the relationship between emotional disturbances and somatic complaints and has taught me something of the methods of obtaining the necessary information from the patient so that I can know what these emotional factors are. But after I have the information I do not feel competent or clear as to what I should do with it.

The general reaction to the course was well expressed by a man who, though over age according to the original plan, was admitted because of his insistence. He wrote:

I came here very humble and am leaving feeling much the same,

and more so. What little psychosomatic medicine I practiced was by groping and feeling my own way. This course has opened new vistas of medicine—new concepts of obtaining a history and treatment. One cannot help but see the great number of patients who need this type of therapy. Most of them had me licked; in the future fewer of them will be able to say this. . . . I believe I shall practice better medicine in the future; take more time for each patient; and practice with more equanimity.

Equanimity is an asset for good medicine. The doctor's own sense of frustration, and his irritation at the patients who frustrate him, have often tied his hands. The realization that what they learned in this course would help them with their most discouraging patients was evidently a major cause of the older students' satisfaction. One young man summed up the whole matter by saying that the course had given him a much keener realization of his obligations as a physician.

Comments from several men suggested that the informality of the course (in which students and instructors were housed together, ate together, and palavered together at all hours) and the simplicity of presentation were important aids in the learning process. One man wrote that the faculty was "so non-professorial"; another, ". . . the fundamentals were presented without the use of many new terms. . . . I was pleased that the instructors did not at any time 'talk down' to the students." The teamwork on the part of the instructors, who as a matter of fact did subordinate their occasional differences of opinion in order to present an integrated concept of psychotherapy, was appreciated especially by men who knew that such agreement did not come about by chance.

Although the didactic material was concentrated, and some men freely admitted that (especially in the early part of the course) they found it difficult because of their own lack of

preparation, the consensus was that the content was clear and of practical value. Some men found it illuminating in terms of previous reading of their own; some men took it as a useful guide to future reading. It seems reasonable to believe that nearly all of them grasped the essential points—the significance of the doctor-patient relationship; the interplay of emotion, physiological function, and disease; the need for comprehensive diagnosis and therapy; and the usefulness of the interview in both. Most of the men learned, in the lecture room and clinic, to approach patients more helpfully, to take a better history, and to use rapport consciously as a resource in treatment.

As one of the instructors said, there is a ladder of accomplishment, of which the first rung is interest; the second, understanding; the third, skill; and the fourth, judgment. These men all took the first and, in some measure, the second step. At the third level, some had a native skill in dealing with people which this experience reinforced. The fourth step, judgment, comes only through long experience. To take even the first and second steps was exciting and rewarding; it pointed the way toward better medicine.

For the instructors also this course was a rewarding experience. They were young men, with strong convictions. They believed that psychiatry was concerned with personal relationships, depended for its therapeutic value on personal relationships, and should be taught accordingly. They welcomed an opportunity to show how creative this point of view could be in a teaching situation free of the rigidities of the conventional curriculum. They believed, moreover, that people handicapped by psychoneuroses are not now being adequately

helped by American physicians. They felt the burden of finding out how to better this situation. Realizing the sharp limitations on what psychiatrists could do alone, they were encouraged by discovering that men in general practice could learn so much and so readily about ways of helping psychoneurotic patients. After this course it seemed quite unnecessary to take counsel with the pessimists and write off the present generation of men in practice as too old to learn the psychotherapy they had never been taught. The physicians present at Minneapolis, at least, were both eager and quick to learn. From this point of view the instructors felt the course to be a success.

This general feeling of satisfaction was tempered by a realistic appraisal of what could and could not be done in two weeks. The overall purpose of the course was, as one instructor put it, to sensitize doctors to emotional problems in their medical practice. This, the instructors felt, was accomplished. When this general statement was broken down, degrees of accomplishment became clearer. In retrospect specific goals were defined somewhat as follows:

1. To give the doctor a feeling of the dynamic qualities and the value of the doctor-patient relationship.
2. To introduce him to broad patterns of human motivation and to the common causes and backgrounds of emotional disturbance.
3. To lead him to think in terms of the relation between emotional disturbance and illness.
4. To teach him easily understandable methods of therapy so that he can treat a share of such illness.
5. To give him some knowledge of more malignant conditions so that he may refer them to specialists.

The first of these objectives was unquestionably reached; rather by identification with the instructor, perhaps, than by

an intellectual process. This was a point at which feeling was quite as important as understanding; perhaps more so.

The second objective was achieved in general terms. No firm grasp of any comprehensive theory of human behavior is to be had in two weeks, but at least the students were led to see emotional phenomena in a biological rather than a moral or mechanical perspective. Their own knowledge of people and abundant illustrations drawn from the instructors' experience as parents and therapists documented the theory.

The third objective was reached, at least in principle. This kind of thinking was accepted by some students only after a real struggle to reconcile it with the mechanistic etiology in which they had been trained. In a longer course, with more clinical experience, students might be able to work out the relation between emotional disturbance and illness in specific cases for themselves. Here they had to take it mostly on faith.

The fourth objective—the learning of therapeutic methods —is one in which the limitations of a two-weeks course are most evident. Few or none of the men learned to see therapeutic possibilities clearly or to formulate treatment plans. Perhaps the most that could be expected was that they should learn to do no harm — whether by overexamination, hasty diagnosis, or ill-advised treatment—and to give the patient the relief that comes from talking out his troubles. This, the instructors thought, was accomplished, and growing experience would gradually increase the doctors' ability to carry treatment further.

The fifth objective, too, was one that could be only partly reached. The intelligent selection of cases for treatment at varying levels of intensity requires a skill quite beyond the reach of men so briefly trained. It was possible to warn the students against dangerous ways of handling severely ill

patients, and in general to caution them against attempting to deal with unconscious material. Most of these doctors were not without experience in dealing with psychotic patients. Their maturity and common sense were, in the opinion of the instructors, reasonable insurance against serious clinical errors.

On the major strategy of reaching these goals the instructors were in good agreement. The emphasis and sequence of the didactic material had been carefully planned in advance and the last-minute changes in the schedule did not alter its trend. This was to present personality, its development and its disorders, and the doctor's opportunity to deal with those disorders, in simple and dynamic terms, and to keep hammering at the major points by statement and restatement with all the variety a diversified group of teachers could give them. The play of forces within the personality and between persons was the central theme. This gave vitality to the lectures and made the content seem fresher and more usable than the kind of neuropsychiatry these men had previously been taught.

The more stress on dynamic material, the more need for exhibiting it in action. The heart of the course was the clinical teaching. One instructor, after a week's experience, felt that an hour a day of straight didactic teaching was all that should be attempted, but several wished, in retrospect, that there had been more time for intensive supervision of the students' work in the clinic. "One might create a general rule," one instructor commented, "that the excellence of the teaching program is roughly proportional to the number of hours of individual supervised instruction received and the quality of the supervision. No amount of skilful lecturing will replace the value of individual supervision in regard to a specific case." In the lecture room the presence of a rather large group of instructors was an asset; one reinforced another and there

was repetition without monotony — indispensable to good teaching. In the clinic the large staff was an absolute necessity, and a larger group would have been desirable to permit more individual instruction. The most serious pedagogical question which arose in retrospect was whether a better preparation could have been given the students for their first interview by demonstrating as well as discussing interview techniques.

The rapport between students and instructors was vital to the learning process. The evident hunger of the students for knowledge in this area of medicine was its substrate. The instructors brought to the task of teaching the same sort of skills they were accustomed to use in establishing rapport with patients. They endeavored to teach, as one said, "with warmth, conviction, and enthusiasm, at an intimate but not frightening level." They were themselves learning how to do a job for which there were few precedents. The students shared the experimental flavor of the experience. The stuff they worked on—instructors and students together—was the stuff of life itself.

The ineptness of many of the students in their first contacts with patients and the rigidity of their diagnostic approach reflected a lack in their professional training. Many good medical schools have failed to teach the art of medicine. There was some disagreement as to whether the best time to do this sort of teaching was in the undergraduate or postgraduate years. These men were readier to learn because they had already felt in their own practice the limitations of a narrower sort of diagnosis and therapy, and certainly they grasped the underlying concepts of the course more quickly because they knew people. In these respects they were at some advantage over the undergraduates. On the other hand, a few of the student-doctors, comparing this kind of medicine with what

they themselves had been practicing for years, felt a degree of guilt which might have been a handicap in the learning process; this could not have occurred with undergraduates. It seemed to the instructors that the course held valuable implications for both undergraduate and house-officer training. However that may be, it certainly offered good evidence that psychotherapeutic medicine can and should be a part of post-graduate medical education wherever serious students, skilful teachers, and clinical material can be brought together.